5.4 SEX OFFENDER TREATMENT

Although the majority of the priests and deacons accused of child sex abuse have had only one allegation, there were two types who had inspired more concern – those priests who had multiple victims and those who abused one victim for a lengthy period of time. The aims and types of treatment for sexual offenders have changed significantly throughout the past century, which is important when understanding the types of treatment clergy have undergone since the 1950s. In the early 20th century, psychologists thought sexual offending was the result of individual psychological conflicts. As a result, many of the first treatments were psychoanalytic in nature. They were based upon a model, which implied that offending was out of the individual's control. Early psychoanalysts believed that if treatment were to occur it would have to be lengthy in order to adequately address and resolve the problem. [1]

In the 1950s, psychological methods of treatment for sexual offenders began to change.[2] Many researchers at this time believed that deviant sexual practices resulted from deviant sexual arousal, and therapeutic practices were developed to modify deviant fantasies. They took various forms, such as operant conditioning,[3] aversion therapy,[4] orgasmic reconditioning,[5] and shaping.[6] The focus was not only on modifying serious sexual fantasies, such as those about children, but also on eliminating homosexual desires.

The first behavioral treatment programs were limited in scope and concentrated upon single elements of deviant behavior. Some researchers then expanded upon these and made the programs multi-modal in nature. Through the addition of treatment components, such as social skills training, clinicians attempted to address the many factors shown by research to be associated with offending behavior. Treatment providers such as Abel recognized that sex offenders evidenced had a high prevalence of cognitive distortions, or thought processes that allowed the offenders to neutralize their feelings of guilt and shame. He and other treatment providers began to modify behavioral treatment programs so that they were cognitive-behavioral in nature in order to address these distortions.[7] In the 1980s, the cognitive behavioral treatment programs were further expanded to include the therapeutic technique of relapse prevention, which is a strategy for maintaining treatment-induced changes through self-management. This was originally developed as a model for controlling substance abuse and was later adapted by Pithers and his colleagues to address deviant sexual behavior. [8]

Relapse prevention is said to be one of the most important developments for sex offender research of that decade since offenders were finally trained to recognize and manage their own fantasies and behavior.[9] Other developments in the 1980s involved cognitive restructuring, victim empathy training, the refinement of sexual arousal monitoring, and an increased validity of phallometric testing (a measure of arousal assessment).[10] The most significant addition to treatment in the 1990s was the use of the polygraph. Though polygraph results are generally not admissible on trials of guilt or innocence, the polygraph does produce usable information about deception and gives treatment providers deeper insight into the acts committed by offenders and shows whether they are being truthful during the treatment programs.

Although it is clear that there is no cure for sex offenders, certain treatment regimes appear to be successful at reducing rates of recidivism for certain types of offenders. Unfortunately, it is not possible to present definitive statistics on the reduction of recidivism due to the numerous methodological problems associated with sex offender treatment.

The study data showed that 1,627 priests had been provided with some form of sex offender treatment, and 1,394 had been sent to a specific sex offender treatment facility at least once. Of those whose problems had prompted sex offender treatment, a substantial number, 744, or 45.7%, received more than one type of treatment. Of this group of 744 priests, a majority of 425, or 57%, participated in some form of treatment three times and 244, or 32.8%, four times. The handwritten notes on the surveys for these latter two groups of priests detailed the continuing efforts of diocesan and religious community leaders to respond constructively to sex abuse problems.

Table 5.4.1. TYPE OF SEX OFFENDER TREATMENT

Type of Treatment	Count	Percent of cases
Specialized program for clergy sex offenders	666	41%
Specialized program for sex offenders	212	13%
General treatment/program	283	17.4%
Individual psychological counseling	679	41.7%
Psychotherapy	412	25.3%
Relapse prevention program	170	10.4%
Evaluation, but not treatment	293	18%
Spiritual counseling	224	13.8%
Other	102	6.3%0

This is a multiple response table. The categories are not mutually exclusive, since a priest may have received more than one form of treatment.

Individual priests often received multiple forms of treatment either simultaneously or consecutively. This table describes 3,041 instances of treatment or evaluation of 1,627 individual priests.

Table 5.4.2. TREATMENT FACILITIES USED

Facility Name	Count	Percent of all cases
Behavioral Medicine Institute / -Atlanta, GA	8	.6%
Issac Ray Center /- Chicago, IL	50	3.6%
John Hopkins Medical Center/ Baltimore, MD	10	.7%
Progressive Clinical Services /-Cincinnati, OH	5	.4%
St. Luke Institute /- Suitland, MD	465	33.4%
Servants of the Paraclete / St. Louis, MO	115	8.2%
Shalom Center / Splendora, TX	23	1.6%
Southdown / Ontario, CANADA	113	8.1%
Servants of the Paraclete / Jemez Springs, NM	197	14.1%
Servants of the Paraclete /Albuquerque Villa, NM	36	2.6%
St. Louis Consultation Service / St. Louis, MO	61	4.4%
Institute of Living / Hartford, CT	99	7.1%
Menninger Clinic / Topeka, KS	4	.3%
New Life Center / - Middleburg, VA	8	.6%
Villa St. John Vianney /- Dowingtown, PA	138	9.9%
Other	337	24.2%

This is a multiple response table. The categories are not mutually exclusive, since a priests may have been treated in the same facility more than once, or in more than one facility.

The survey respondents reported that 158 priests had been treated at a residential facility more than once.

[1] Organic, or medical, treatments for sexual offenders surfaced in the 1940s. These treatment approaches are not discussed at length here because they have rarely been used for clergy abusers. The first hormonal treatment in the 1940s was an estrogen called, which proved to be fairly successful at reducing deviant sexual behavior. Despite its benefits, it was not widely used because of its side effects which included vomiting, nausea and feminization. The idea that sexual offending was a medical problem continued through the 1950s and the 1960s, with the introduction of medical treatments such as medroxyprogesterone acetate (MPA), which is still used today with "chemical castration" (more commonly referred to as Depo Provera).

[2] It was Eysenck's criticism of traditional psychotherapy that facilitated the move towards behavioral therapy as the preferred form of psychological treatment (Marshall et al, 1999).

[3] B.F. Skinner. *Science and Human Behavior* (New York, NY: The Free Press, 1953).

[4] R. McGuire and M. Vallance. "Aversion Therapy by Electric Shock: A Simple Technique," *British Medical Journal* 2 (1964): 594-597.

[5] John N. Marquis, "Orgasmic Reconditioning: Changing Sexual Object Choice Through Controlling Masturbation Fantasies," *Journal of Behavior Therapy & Experimental Psychiatry*, 1(1970): 263-271.

[6] John Bancroft. "The Application of Psychophysiological Measures to the Assessment and Modification of Sexual Behavior," *Behavior Research and Therapy* 9 (1971):119-130.

[7] Gene G. Abel. "Behavioral Treatment of Child Molesters," in *Eating, Sleeping, and Sex: Perspectives in Behavioral Medicine*, ed. Albert J. Stunkard and Andrew Baum (Hillsdale, NJ: Lawrence Erlbaum Associates, 1989): 223-242.

[8] Pithers note

[9] William L. Marshall, "Assessment, Treatment, and Theorizing about Sex Offenders: Developments During the Past Twenty Years and Future Directions," *Criminal Justice and Behavior* 23(1996):162-199.